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Health Indicators of the National Roma Integration Strategy in Spain in the years 2006 and 2014

ABSTRACT

Background. In 2011 the European Commission adopted the European framework for the National Roma Integration Strategies (NRIS) 2020, which focused on four areas: education, employment, health and housing. In 2012 Spain approved its Strategy 2012-2020, one of the central aims of which is to reduce social inequalities in health that affect the Roma population. Our objective was to analyse changes in health inequalities between the Roma population and the general population in Spain in the years 2006 and 2014.

Methods. The Spanish National Health Surveys 2006 (n= 29,478) and 2012 (n =20,884) and the National Health Survey of the Spanish Roma Population 2006 (n = 933) and 2014 (n = 1,155) were compared. This study considered the variables included in NRIS 2012-2020: self- perceived health; tobacco use in men; traffic accidents in men and women; obesity in women; and gynaecological visits.

Results. Despite the adoption of the NRIS 2012-2020, there were no observed improvements in health between 2006-2014 in the Roma population. Nor was there a reduction in inequalities in health concerning the general population in Spain. Also, there was no reduction in the health inequalities by gender for the two populations.

Conclusions. Health is determined in part by social factors including education, employment, housing and also by anti-Roma discourses and discrimination. Improving the health of the Roma population requires a multi-sectoral approach with a gender perspective.

Keywords: Roma, gypsy, ethnicity, policy, health inequalities, gender

1. Introduction

In 2011 the European Commission adopted the European framework for the National Roma Integration Strategies (NRIS) 2020, which focused on four areas: education, employment, health and housing [1]. In 2012 Spain approved its NRIS 2012-2020, one of the central aims of which is to reduce social inequalities in health that affect the Roma population [2]. This was not the first action taken by the government of Spain to promote the improvement in the living conditions of the Roma population in Spain. A predecessor of the integration strategy was the Action Plan for the Development of the Roma Population 2010-2012 [3], which was approved four years after the first health survey of the Roma population (HSRP). The survey was carried out in 2006 by the Ministry of Health in collaboration with the Roma Secretariat Foundation and used a methodology that allowed for comparison of the results with those of the National Health Surveys (NHS) carried out by the Ministry of Health in collaboration with the National Statistics Institute. The results of the comparison of both sources highlighted the existence of large and relevant gaps in many areas of perceived health, lifestyles and access to health services between the Roma population and the general population in Spain [4]. This was true even when the Roma population was compared with occupational classes in the worst situations in the general population [5].

The theory of fundamental causes [6,7] posits that being of low socioeconomic status (SES) is a known social determinant of health throughout life [8]. This is because it brings together a set of conditions that perpetuate each other and persist over time. These conditions include educational deficiencies, low levels of monetary resources, few local connections and low levels of power. Now, in addition to their usual low levels of SES, Roma people suffer from the additional effects of exclusion, intolerance and rejection[3]. This is the starting point that allows us to define health inequality as health differences

that are avoidable, unnecessary, and unjust, as laid out in Margaret Whitehead's definition [9]. As Paula Braverman proposed, health disparities are the metric used to measure progress toward achieving health equity. A reduction in health disparities is evidence that we are moving toward greater health equity[10]. In theoretical terms, this suggests a situation of stigmatization [11] that includes the existence of labelling processes, stereotypes, separation and loss of status of the Roma people. An indirect process of institutional discrimination could also be at work, such that public health services operate through norms that correspond to the culture of the majority of the population. This definition implies the existence of avoidable disparities, which must be faced using resources and cultural sensibility in the practice of medical care, and also promoting healthier behaviours and better income and living conditions, focusing the efforts on Roma people but considering all disadvantaged groups.

In the Spanish NRIS there is a total of eight quantifiable objectives in the area of health. Five refer to the adult population and three to the child population: self-perceived health, accidents (adults and child population), tobacco use, obesity (in adult women and children), gynaecological visits and dental care (child population only). These were developed based on the estimations carried out in 2006 and with objectives for the years 2015 and 2020.

In the year 2014 there was a second survey of the Roma population [12] that used a methodology comparable to the 2006 surveys and allowed for evaluation of whether there was a convergence of the objectives set out for the Strategy for 2015.

Among the objectives in the NRIS, there are indicators of access or utilisation of services (gynaecological visits, dental care), personal behaviour linked to life situations (accidents, tobacco use, obesity) and a synthesis indicator widely used in scientific health studies (self-perceived health)[5,13,14]. The Strategy does not provide a theoretical

basis for the reasons why Spain selected these indicators and not others. The objective of this study is to determine whether there was progress towards the Strategy goals and whether there was a reduction in health disparities between the Roma and the general populations considering these indicators, globally and by sex.

2. Methods

2.1. Participants and data collection

The analysis was carried out based on data from four surveys. Two of them were the National Health Surveys (NHS) of 2006 and of 2012. These surveys are carried out every five years by the Ministry of Health and the Spanish National Statistics Institute. They apply tri-stage random stratified sampling (by census sections, households and persons) and are representative of the total Spanish population. The NHS of 2006 was carried out between June of 2006 and June of 2007. The sample size was 38,600 persons, of which there were 29,478 adults (age 16 and over). The NHS of 2012 had a sample of 26,502 persons, of which 21,007 were considered adults (age 15 and over). People aged 15 years were removed from the 2012 database, so the final database contained 20,884 persons aged 16 years and over.

We also used the Health Survey of the Roma Population (HSRP) of 2006 and the HSRP of 2014. Given that there is no official census of the Roma population in Spain, the sampling design of these surveys used estimates of the number of Roma people, as calculated in previous studies. Available estimates of the Roma population in Spain during the study period range between 1.5 percent (700,000 Spaniards who are Roma/Kale) and 2.1 percent (970,000) of the total population in the country[15]. Quotas were calculated with information on the distribution of this population in the 17 autonomous communities that comprise Spain, grouped by age, sex, and city size. Finally, as in the case in the NHS, a multi-stage sampling procedure was used (location stratified by size, neighbourhood, households and persons), that followed random routes. The HSRP in 2006 was carried out via an agreement between the Ministry of Health and the Roma Secretariat Foundation. The fieldwork was executed between September and November of 2006, and the sample collected contained 933 persons. The

HSRP of 2014 was developed via an agreement between the Ministry and a research group at the University of Alicante, between December of 2013 and May of 2014. It was carried out with a sample of 1,167 persons, of which 1,155 were selected as being age 16 or older.

2.2. Measures

The questionnaires of the HSRP replicated the health questions of the NHS, which assured comparability between the two sources. The study variables were self-perceived health (dichotomized by combining the responses of very poor, poor and regular into a "less than good" category, and the good and very good responses into a "good or very good" category); tobacco use in men (those who smoke daily versus an occasional smoker, non-smoker or ex-smoker); traffic accidents in men and women (having suffered an accident in the past 12 months); obesity in women (body mass index equal or greater than 30) and visits to the gynaecologist (women who had never paid a visit to the gynaecologist compared to those that did). These were also the variables contained in the NRIS 2012-2020.

2.3. Compared groups

We established four comparison groups for analysis, respectively denominated general Spanish population to refer to the population included in the samples of the two NHS surveys (2006 and 2012) and Spanish Roma population to refer to the population included in the two HSRP surveys (2006 and 2014). To carry out the analysis, the four samples were combined into a single database.

2.4. Analysis

Logistic regression models were used, with the health variables indicated in the prior

paragraph used as outcome variables (dichotomized).

All of the analyses were adjusted for age (introduced as a continuous variable), from 18 years for the indicator of obesity, between 35 and 54 years for self-perceived health, and from 16 years for all others indicators. The analysis was also carried out stratified by gender.

To evaluate the variance in gaps, the Firebaugh (1989) proposal was used, which indicates that one way to determine whether there is a statistically significant increase in the distance between two categories using surveys that are repeated in time, is by including in the logistic regression models an interaction effect between the category variables and the variable time. Thus, in the models that evaluate the gap between populations, the interaction variable 'population group *time' was used. In the models to evaluate the gender gap, the interaction variable 'gender*time' was used. The results are shown in terms of odds ratios with 95 percent confidence intervals.

3. Results

The results obtained show : a) changes in the indicators for both the Roma and the general population between 2006 and 2012/2014 (Table 1); b) the health inequality observed between the general population and the Roma population (Table 2); c) the changes in health inequality between the Roma and general populations (Table 2); and d) the transformation of the gaps in gender, both for the Roma and general populations (Table 3).

Between 2006 and 2014 there were no significant improvements for the Roma population in terms of the majority of the indicators included in the Strategy (Table 1). The variation observed was situated within the margins of random error and was not statistically significant for all of the indicators analysed, with the exception of visits to the gynaecologist for reasons other than pregnancy or birth. This was the only indicator for which there was an improvement for the Roma population (the percentage of Roma women who had never been to the gynaecologist decreased from 24.3 percent in 2006 to 16.3 percent in 2014). However, the general population showed significant improvements not only for this indicator (from 17.3 percent to 13.7 percent), but also for the indicators of self-perceived health (both men and women) and daily tobacco use (both men and women). This was also observed in the logistic regression model, given that the improvement for the Roma population in Spain in both years in terms of gynaecological visits reflects an OR = 0.61 [0.45;0.83], which also occurred for the general population: OR = 0.76 [0.71;0.81]. Conclusively, and as shown in Table 2, the improvement in the indicator related to visits to the gynaecologist among the Roma population did not translate into a reduction in inequality, given that there was improvement in this indicator for women in the general population as well.

In 2006 there were important health differences observed for all of the included indicators (Table 2). These were always unfavourable for the Roma population and ranged between an odds ratio (OR) of 2.85 [2.32;3.50] in the case of obesity in women and an OR of 1.52 [1.24;1.86] for women who have never paid a visit to the gynaecologist.

In terms of the gaps observed between the Roma and general populations (interaction term in Table 2), the results seem to point to a reduction in the gap between Roma women and women in the general population both in terms of obesity and in the lack of gynaecological visits, but the results indicate that this reduction was not statistically significant. In this way, we can conclude that there was no significant reduction in health inequality between 2006 and 2012/2014 for any of the analysed indicators.

On the contrary, the OR =1.29 [1.00; 1.67] supposes an increase in inequality in terms of tobacco use among men given that there was a decrease in the use among the general population and no change among the Roma population.

Considering the differences by gender, the data showed the existence of gender-related health differences, both in 2006 and in 2012/2104, although these differences depend on the population under study. For example, there were statistically significant differences between men and women in tobacco use in both years, both in the general population and in the Roma population, but these differences only occurred in the Roma population in 2006 for the obesity indicator. In any case, all health indicators showed differences by sex, in at least one population between 2006 and 2102/2014. Thus, the need to stratify all data analyses by sex was apparent, and we did so in order to observe potential changes in the gender gap. Tables 1 and 3 show the results in terms of this gap.

Men had better self-perceived health in both populations. While there was a greater proportion of smokers among the male Roma population, the lowest proportion of smokers was found among Roma women. In the case of traffic accidents, the most positive indicator was for general population women, while for the Roma population there was no difference by gender for this indicator. Obesity was most frequent among Roma women and in men than in the general population. The gap between men and women (interaction term in Table 3) in 2012/14 compared with 2006 was maintained for all of the indicators, except for obesity, where there was a reduction in the inequalities by gender for the two populations (because men were more likely to be obese in 2012/2014), and a small increase in tobacco use inequality by gender for the general population.

4. Discussion

There were no improvements for Roma population health observed in the period 2006-2014, nor was there a reduction in health inequality with respect to the general population, nor was there a reduction in the gender gap in health for either of the two populations, despite the approval of the National Roma Integration Strategy in Spain 2012-2020 (preceded by the Action Plan for the Development of the Roma Population 2010-2012) and the measures taken to promote gender equality approved by the Spanish government. There was also no substantial increase in the health gap between the Roma and the general population in Spain in the analysed period.

In interpreting these results it is important to consider some limitations. One of them is that the timeframe for the analysis of 2006-2014 could be insufficient for achieving the Strategy's ambitious objective of a general reduction in inequality in various health indicators, especially when these inequalities are determined by institutionalized systems of ethnic and gender domination [14,17–20]. It would even be possible that the few changes observed could have occurred before the implementation of the Strategy, given that our first source of data for both populations was from 2006.

In order to achieve the substantial objectives of the National Strategy, especially in terms of ethnic inequalities, a specific approach would be required with a focus on the social determinants of health [21]. This is because of the intersection of different axes of inequality- such as ethnicity, gender and social class- that make for a qualitatively different problem [22]. In this case an approach that emphasizes changes in the prevalence of health problems among a whole population group (the Roma population) would be insufficient [23,24]. Addressing the needs of specific groups for whom the different social determinants of health converge is needed [25–28]. Furthermore, it was beyond the scope of this study to determine to what extent the fulfilment of the objectives of the Spanish

National Strategy indicates the effective mitigation of health disparities. Posterior research is required to observe whether the changes in the indicators integrated in this policy are consistent with other evolving health indicators of the Roma population.

Also, in the study samples used in the Roma population surveys (993 and 1,155 persons, or half of this number when analyses are stratified by gender) statistical power was reduced, which makes finding statistically significant results between the study years more difficult. We also cannot discard possible statistical artefact given that both the NHS and HSRP have undergone methodological and operational changes (for example, in the NHS 2012 the fieldwork was outsourced). And finally, it should be noted that, although transversal studies across time are the only available instrument in this context to analyse the issue at hand, cohort/panel or longitudinal studies are the tool that is recommended to carry out impact evaluations [29].

Despite these limitations, the results of this analysis point out an unfortunate situation of gender and ethnic inequality that persists over time. Concerning ethnicity, there is even an incremental inequality in indicators not included within the objectives of the National Strategy. The Strategy was designed without a prospective approach. Consequently, diverse problems that affect the health of the Roma people could have emerged but not been monitored or evaluated. Our results suggest that there are at least two of these issues: increased obesity among Roma men and the increase in smoking among Roma women.

These results are supported by other studies that use different data sources and methodologies[25,30] and that point to the existence of accumulated institutional practices that operate contrary to the social needs of the Roma population, which can be considered a traditionally stigmatized population [11]. That is to say that an indirect process of institutional discrimination could operate to the extent that public health

services operate governed by norms that correspond to the culture of the majority. This could be one of the reasons why Roma women have shown low rates of gynaecological consultations, which was one of the objectives included in the health section of the National Integration Strategy.

Like the European Commission has recently stated[31]:

"Inclusion of Roma happens when mainstream policies are responsive to their specific needs. Most current policies aimed at Roma inclusion lack a systemic perspective. The evaluation finds that national authorities should follow a twin strategy of making mainstream services inclusive and providing programmes that are targeted towards those who are most vulnerable."

This is very similar to what had already been repeatedly recommended in the social determinants of health framework: there is a need for a broader structural multi-sectoral polices to bring this about[32–34].

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Conflicts of interest: None declared.

Key Points

- There were no improvements for Roma population health observed in the period 2006-2014, nor was there a reduction in health inequality concerning the general population.
- There was no reduction in the health inequalities by gender for the two populations in 2012/14 compared with 2006, except for obesity.
- Health inequality persisted despite the approval of the National Roma Integration Strategy 2012-2020 in Spain and the measures taken to promote gender equality approved by the Spanish government.

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